MAINE DEPARTMENT OF HEALTH & AND HUMAN SERVICES

Health and Environmental Testing Lab
221 State Street, SHS 12
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HETL

FLUORIDE TEST KIT REQUEST

Name: _____

Address: _____

Town, State, Zip Code:_____

Phone #: _____

The cost of the fluoride test is $14.00. Please enclose a check or money order made out to "Treasurer, State of Maine". Do **not** send cash. For your convenience, payment may be made by Visa or MasterCard.

Visa ☐ MC ☐ Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date ☐☐/☐☐

_____ $ _____

Signature of Card Holder Amount

If you have a problem paying for this test, the cost **may** be waived. However, you must meet **ALL** of the following conditions.

- ☐ The water you drink comes from a private well, and not from a public water system.
- ☐ There is an existing health condition or a professional reason to get this test result. Examples include:
  - ☐ a medical or dental health provider's advice that your water be tested because of an existing illness or health-related need, such as existing dental disease (tooth decay), a high risk for dental disease, and/or the need to determine the correct level of fluoride supplements **OR**
  - ☐ unnatural contamination, such as suspected waste or spills that contaminate nearby groundwater.
- ☐ You provide proof that you participate in any of these programs: Food Stamps, TANF, WIC, or MaineCare. Write the program name and your ID number in the spaces at the bottom of this form.
- ☐ **You must provide the information listed here at the same time as this test request**. Please write the name of the program and your ID number in the spaces below, and enclose a copy of the medical or professional justification with this form, **or,** use the list as a checklist and have the health provider sign it. **Please note: If all of the requested information is not submitted together with this request, your request for a fee waiver will be denied.**

Program Name: _____ ID Number: _____

Health Provider signature: _____

REVISED 07/30/04